As Introduced

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H. B. No. 179

Representative Blessing

A B I L L

To amend sections 126.30, 1751.55, 1751.60, 3923.05, 3923.36, 3923.65, 3923.66, 3923.75, 3924.61, 4121.01, 4121.44, 4121.441, 4121.442, 4123.01, 4123.30, 4123.343, 4123.35, 4123.511, 4123.512, 4123.82, and 4123.93 and to enact section 4123.513 of the Revised Code to require a health insurer and allow an employee, during the time an employee's workers' compensation claim is pending approval, to pay for services provided to care for an employee's workplace injury or occupational disease and to require the Administrator of Workers' Compensation or a self-insuring employer, as appropriate, to reimburse that health insurer or employee for expenses they paid for a claim once it is deemed compensable.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 126.30, 1751.55, 1751.60, 3923.05, 3923.36, 3923.65, 3923.66, 3923.75, 3924.61, 4121.01, 4121.44, 4121.441, 4121.442, 4123.01, 4123.30, 4123.343, 4123.35, 4123.511, 4123.512, 4123.82, and 4123.93 be amended and section 4123.513 of the Revised Code be enacted to read as follows:

Sec. 126.30. (A) Any state agency that purchases, leases, or otherwise acquires any equipment, materials, goods, supplies, or services from any person and fails to make payment for the equipment, materials, goods, supplies, or services by the required payment date shall pay an interest charge to the person in accordance with division (E) of this section, unless the amount of the interest charge is less than ten dollars. Except as otherwise provided in division (B), (C), or (D) of this section, the required payment date shall be the date on which payment is due under the terms of a written agreement between the state agency and the person or, if a specific payment date is not established by such a written agreement, the required payment date shall be thirty days after the state agency receives a proper invoice for the amount of the payment due.

(B) If the invoice submitted to the state agency contains a defect or impropriety, the agency shall send written notification to the person within fifteen days after receipt of the invoice. The notice shall contain a description of the defect or impropriety and any additional information necessary to correct the defect or impropriety. If the agency sends such written notification to the person, the required payment date shall be thirty days after the state agency receives a proper invoice.

(C) In applying this section to claims submitted to the department of job and family services by providers of equipment, materials, goods, supplies, or services, the required payment date shall be the date on which payment is due under the terms of a written agreement between the department and the provider. If a specific payment date is not established by a written agreement, the required payment date shall be thirty days after the department receives a proper claim. If the department determines that the claim is improperly executed or that additional evidence of the validity of the claim is required, the department shall

notify the claimant in writing or by telephone within fifteen days after receipt of the claim. The notice shall state that the claim is improperly executed and needs correction or that additional information is necessary to establish the validity of the claim. If the department makes such notification to the provider, the required payment date shall be thirty days after the department receives the corrected claim or such additional information as may be necessary to establish the validity of the claim.

(D) In applying this section to invoices submitted to the ~~bureau~~ administrator of workers' compensation for equipment, materials, goods, supplies, or services provided to employees in connection with an employee's claim against the state insurance fund, the public work-relief employees' compensation fund, the coal-workers pneumoconiosis fund, or the marine industry fund as compensation for injuries or occupational disease pursuant to Chapter 4123., 4127., or 4131. of the Revised Code, the required payment date shall be the date on which payment is due under the terms of a written agreement between the ~~bureau~~ administrator and the health care provider. If a specific payment date is not established by a written agreement entered into between the administrator and the health care provider, or if a health insurer or an employee submits the invoice to the administrator pursuant to section 4123.513 of the Revised Code, the required payment date shall be thirty days after the ~~bureau~~ administrator receives a proper invoice for the amount of the payment due or thirty days after the final adjudication allowing payment of an award to the employee, whichever is later. Nothing in this section shall supersede any faster timetable for payments to health care providers contained in sections 4121.44 and 4123.512 of the Revised Code.

For purposes of this division, a "proper invoice" includes the claimant's name, claim number and date of injury, employer's

name, the health care provider's name and address, the health care provider's assigned payee number, a description of the equipment, materials, goods, supplies, or services provided by the provider to the claimant, the date provided, and the amount of the charge. If more than one item of equipment, materials, goods, supplies, or services is listed by a health care provider on a single application for payment, each item shall be considered separately in determining if it is a proper invoice.

If prior to a final adjudication the ~~bureau~~ administrator determines that the invoice contains a defect, the ~~bureau~~ administrator shall notify the health care provider in writing at least fifteen days prior to what would be the required payment date if the invoice did not contain a defect. The notice shall contain a description of the defect and any additional information necessary to correct the defect. If the bureau sends a notification to the provider, the required payment date shall be redetermined in accordance with this division after the bureau receives a proper invoice. If after a final adjudication a health insurer or employee submits a copy of an invoice to the administrator under section 4123.513 of the Revised Code and the administrator determines that the invoice contains a defect, the administrator shall notify the health insurer or employee in writing at least fifteen days prior to what would be the required payment date if the invoice did not contain a defect. The notice shall contain a description of the defect and any additional information necessary to correct the defect. If the administrator sends a notification to the health insurer or employee, the required payment date shall be redetermined in accordance with this division after the administrator receives a proper invoice.

For purposes of this division~~, "final~~:

(1) "Health insurer" has the same meaning as in section 4121.01 of the Revised Code.

(2) "Final adjudication" means the later of the date of the decision or other action by the ~~bureau~~ administrator, the industrial commission, or a court allowing payment of the award to the employee from which there is no further right to reconsideration or appeal that would require the ~~bureau~~ administrator to withhold compensation and benefits, or the date on which the rights to reconsideration or appeal have expired without an application therefor having been filed or, if later, the date on which an application for reconsideration or appeal is withdrawn. If after final adjudication, the administrator ~~of the bureau of workers' compensation~~ or the industrial commission makes a modification with respect to former findings or orders, pursuant to Chapter 4123., 4127., or 4131. of the Revised Code or pursuant to court order, the adjudication process shall no longer be considered final for purposes of determining the required payment date for invoices for equipment, materials, goods, supplies, or services provided after the date of the modification when the propriety of the invoices is affected by the modification.

(E) The interest charge on amounts due shall be paid to the person for the period beginning on the day after the required payment date and ending on the day that payment of the amount due is made. The amount of the interest charge that remains unpaid at the end of any thirty-day period after the required payment date, including amounts under ten dollars, shall be added to the principal amount of the debt and thereafter the interest charge shall accrue on the principal amount of the debt plus the added interest charge. The interest charge shall be at the rate per calendar month that equals one-twelfth of the rate per annum prescribed by section 5703.47 of the Revised Code for the calendar year that includes the month for which the interest charge accrues.

(F) No appropriations shall be made for the payment of any

interest charges required by this section. Any state agency required to pay interest charges under this section shall make the payments from moneys available for the administration of agency programs.

If a state agency pays interest charges under this section, but determines that all or part of the interest charges should have been paid by another state agency, the state agency that paid the interest charges may request the attorney general to determine the amount of the interest charges that each state agency should have paid under this section. If the attorney general determines that the state agency that paid the interest charges should have paid none or only a part of the interest charges, the attorney general shall notify the state agency that paid the interest charges, any other state agency that should have paid all or part of the interest charges, and the director of budget and management of the attorney general's decision, stating the amount of interest charges that each state agency should have paid. The director shall transfer from the appropriate funds of any other state agency that should have paid all or part of the interest charges to the appropriate funds of the state agency that paid the interest charges an amount necessary to implement the attorney general's decision.

(G) Not later than forty-five days after the end of each fiscal year, each state agency shall file with the director of budget and management a detailed report concerning the interest charges the agency paid under this section during the previous fiscal year. The report shall include the number, amounts, and frequency of interest charges the agency incurred during the previous fiscal year and the reasons why the interest charges were not avoided by payment prior to the required payment date. The director shall compile a summary of all the reports submitted under this division and shall submit a copy of the summary to the

president and minority leader of the senate and to the speaker and minority leader of the house of representatives no later than the thirtieth day of September of each year.

Sec. 1751.55. A health insuring corporation policy, contract, or agreement shall not be construed to exclude an illness or an injury upon the ground that the subscriber might have elected to have such illness or injury covered ~~by workers' compensation~~ under Chapter 4121., 4123., 4127., or 4131. of the Revised Code ~~unless the policy, contract, or agreement clearly excludes work or occupational related illness or injury, or the policy, contract, or agreement, or a separate writing signed by the subscriber, informs the subscriber that such coverage is excluded and may be available to the subscriber under workers' compensation as the sole proprietor of a business, a member of a partnership, or an officer of a family farm corporation~~. Notwithstanding section 3901.71 of the Revised Code, a health insuring corporation policy, contract, or agreement shall include coverage for an injury or occupational illness that may be covered under Chapter 4121., 4123., 4127., or 4131. of the Revised Code in accordance with section 4123.513 of the Revised Code.

Sec. 1751.60. (A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the

subscriber or enrollee has acted in accordance with the evidence of coverage.

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles.

(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services or from billing the administrator of workers' compensation after a final determination is made pursuant to section 4123.511 or 4123.512 of the Revised Code that the subscriber or enrollee is eligible to receive compensation and benefits under Chapter 4121., 4123., 4127., or 4131. of the Revised Code.

As used in this division, "final determination" has the same meaning as in section 4123.513 of the Revised Code.

(E) Upon application by a health insuring corporation and a provider or health care facility, the superintendent may waive the requirements of divisions (A) and (C) of this section when, in addition to the reserve requirements contained in section 1751.28 of the Revised Code, the health insuring corporation provides sufficient assurances to the superintendent that the provider or health care facility has been provided with financial guarantees. No waiver of the requirements of divisions (A) and (C) of this section is effective as to enrollees or subscribers for whom the health insuring corporation is compensated under a provider agreement or risk contract entered into pursuant to Chapter 5111.

or 5115. of the Revised Code.

(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility.

Sec. 3923.05. Except as provided in section 3923.07 of the Revised Code, no policy of sickness and accident insurance delivered, issued for delivery, or used in this state shall contain provisions respecting the matters set forth in this section unless such provisions are in the words in which the same appear in this section. Any such provisions in any such policy shall be preceded by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent of insurance may approve.

(A) A provision as follows: Change of occupation. If the insured be injured or contract sickness after having changed ~~his~~ the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes ~~his~~ the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof,

whichever is the more recent. In applying this provision, the classification for occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(B) A provision as follows: Misstatement of age. If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(C) A provision as follows:

(1) Other insurance in this insurer. If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... in excess of ..... dollars, the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to ~~his~~ the insured's estate.

The insurer shall insert the type of coverage or coverages in the first blank space in the provision in division (C)(1) of this section and the maximum limit of indemnity or indemnities in the second blank space in the provision in division (C)(1) of this section.

(2) In lieu of the foregoing provision in division (C)(1) of this section, a provision as follows: Other insurance in this insurer. Insurance effective at any time on the insured under a

like policy or policies in this insurer is limited to the one such policy elected by the insured, ~~his~~ the insured's beneficiary or ~~his~~ the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(D) A provision as follows: Insurance with other insurers. If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the provision in division (D) of this section is included in a policy of sickness and accident insurance which also contains the provision in division (E) of this section, the insurer shall add to the caption of the provision in division (D) of this section the following: Expense incurred benefits.

The insurer may at its option include in the provision in division (D) of this section a definition of "other valid coverage" approved as to form by the superintendent. The definition shall not include compensation paid pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code. Such definition shall be limited in subject matter to coverage provided by

organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of the Dominion of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition in the provision in division (D) of this section, "other valid coverage" as used in such provision shall not include group insurance, automobile medical payments insurance, coverage provided pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations.

~~For~~ Except as otherwise provided in this division, for the purpose of applying the provision in division (D) of this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any federal or any other state's workers' compensation law or any employer's liability statute, whether provided by governmental agency or otherwise, shall ~~in all cases~~ be deemed to be "other valid coverage" of which the insurer has had notice. For purposes of division (D) of this section, benefits paid pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code shall not be considered "other valid coverage" of which an insurer has had notice.

In applying the provision in division (D) of this section no third party liability coverage shall be included as "other valid coverage."

(E) A provision as follows: Insurance with other insurers. If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which the insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for

such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

If the provision in division (E) of this section is included in a policy of sickness and accident insurance which also contains the provision in division (D) of this section, the insurer shall add to the caption of the provision in division (E) of this section the following: Other benefits.

The insurer may at its option include in the provision in division (E) of this section a definition of "other valid coverage" approved as to form by the superintendent. The definition shall not include compensation paid pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code. Such definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of the Dominion of Canada, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition in the provision in division (E) of this section, "other valid coverage" as used in such provision shall not include group insurance, coverage provided pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code, or benefits provided by union welfare plans or by employer or employee benefit organizations.

~~For~~ Except as otherwise provided in this division, for the purpose of applying the provision in division (E) of this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including

any federal or any other state's workers' compensation laws or any employer's liability statute, whether provided by a governmental agency or otherwise, shall ~~in all cases~~ be deemed to be "other valid coverage" of which the insurer has had notice. For purposes of division (E) of this section, benefits paid pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code shall not be considered "other valid coverage" of which an insurer has had notice.

In applying the provision in division (E) of this section no third party liability coverage shall be included as "other valid coverage."

(F) A provision as follows: Relation of earnings to insurance. If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or ~~his~~ the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall ~~exced~~ exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall this operate to reduce benefits other than those payable for loss of time.

The provision in division (F) of this section may be placed only in a policy of sickness and accident insurance which the insured has a right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or in a policy of sickness and accident insurance issued after the insured has attained age forty-four and which the insured has the right to continue in force subject to its terms by the timely payment of premiums for at least five years from its date of issue.

The insurer may at its option include in the provision in division (F) of this section a definition of "valid loss of time coverage" approved as to form by the superintendent. Such definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of the Dominion of Canada or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition in the provision in division (F) of this section "valid loss of time coverage" as used in such provision shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(G) A provision as follows: Unpaid premium. Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(H) A provision as follows: Conformity with state statutes. Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum

requirements of such statutes.

(I) A provision as follows: Illegal occupation. The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(J) A provision as follows: Intoxicants and narcotics. The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Sec. 3923.36. No sickness and accident insurance policy shall be construed to exclude an illness or an injury upon the ground that the insured might have elected to have such illness or injury covered ~~by workers' compensation~~ under ~~division (A)(3) of section 4123.01 of the Revised Code unless the policy clearly excludes work or occupational related illness or injury or the policy, or a separate writing signed by the insured, informs the insured that such coverage is excluded and may be available to the subscriber under workers' compensation as the sole proprietor of a business, a member of a partnership, or an officer of a family farm corporation~~ Chapter 4121., 4123., 4127., or 4131. of the Revised Code. Notwithstanding section 3901.71 of the Revised Code, a sickness and accident insurance policy shall include coverage for an injury or occupational illness that may be covered under Chapter 4121., 4123., 4127., or 4131. of the Revised Code in accordance with section 4123.513 of the Revised Code.

Sec. 3923.65. (A) As used in this section:

(1) "Emergency medical condition" means a medical condition that manifests itself by such acute symptoms of sufficient

severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part.

(2) "Emergency services" means the following:

(a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;

(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

(B) Every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage shall cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services.

(C) Every individual policy or certificate furnished by an insurer in connection with any sickness and accident insurance

policy shall provide information regarding the following:

(1) The scope of coverage for emergency services;

(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;

(3) Any copayments for emergency services.

(D) This section does not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time limited duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of federal or another state's workers' compensation or similar law; automobile medical payment insurance; or, except for coverage provided under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Sec. 3923.66. (A) As used in sections 3923.66 to 3923.70 of the Revised Code:

(1) "Clinical peer" and "physician" have the same meanings as in section 1751.77 of the Revised Code.

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of an insured with respect to health care decisions.

(B) Sections 3923.66 to 3923.70 of the Revised Code do not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability

income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of federal or another state's workers' compensation or similar law; automobile medical payment insurance; or, except for coverage provided under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(C) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for review from insureds who have been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the insured's policy or certificate.

On receipt of a written request from an insured or authorized person, the superintendent shall consider whether the health care service is a service covered under the terms of the insured's policy or certificate, except that the superintendent shall not conduct a review under this section unless the insured has exhausted the insurer's internal review process. The insurer and the insured or authorized person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

Unless the superintendent is not able to do so because making the determination requires resolution of a medical issue, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the insured's policy or certificate. The superintendent shall notify the insured and the insurer of its determination or that it is not able to make a determination because the determination requires the resolution of a medical issue.

If the superintendent notifies the insurer that making the determination requires the resolution of a medical issue, the insurer shall afford the insured an opportunity for external review under section 3923.67 or 3923.68 of the Revised Code. If the superintendent notifies the insurer that the health care service is not a covered service, the insurer is not required to cover the service or afford the insured an external review.

Sec. 3923.75. (A) As used in sections 3923.75 to 3923.79 of the Revised Code:

(1) "Clinical peer" and "physician" have the same meanings as in section 1751.77 of the Revised Code.

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a plan member with respect to health care decisions.

(B) Sections 3923.75 to 3923.79 of the Revised Code do not apply to any public employee benefit plan covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of federal or another state's workers' compensation or similar law; automobile medical payment insurance; or, except for coverage provided under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(C) The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for review from plan members who have been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the public employee benefit plan.

On receipt of a written request from a plan member or authorized person, the superintendent shall consider whether the health care service is a service covered under the terms of the plan, except that the superintendent shall not conduct a review under this section unless the plan member has exhausted the plan's internal review process. The plan and the plan member or authorized person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

Unless the superintendent is not able to do so because making the determination requires resolution of a medical issue, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the plan. The superintendent shall notify the plan member and the plan of its determination or that it is not able to make a determination because the determination requires the resolution of a medical issue.

If the superintendent notifies the plan that making the determination requires the resolution of a medical issue, the plan shall afford the plan member an opportunity for external review under section 3923.76 or 3923.77 of the Revised Code. If the superintendent notifies the plan that the health care service is not a covered service, the plan is not required to cover the service or afford the plan member an external review.

Sec. 3924.61. As used in sections 3924.61 to 3924.74 of the Revised Code:

(A) "Account holder" means the natural person who opens a medical savings account or on whose behalf a medical savings account is opened.

(B) "Eligible medical expense" means any expense for a service rendered by a licensed health care provider or a Christian

Science practitioner, or for an article, device, or drug prescribed by a licensed health care provider or provided by a Christian Science practitioner, when intended for use in the mitigation, treatment, or prevention of disease; any amount paid for transportation to the location at which such a service is rendered; any amount paid for lodging necessitated by the receipt of care at a nonlocal hospital; or premiums paid for comprehensive sickness and accident insurance, coverage under a health care plan of a health insuring corporation organized under Chapter 1751. of the Revised Code, long-term care insurance as defined in section 3923.41 of the Revised Code, medicare supplemental coverage as defined in section 3923.33 of the Revised Code, payments made pursuant to section 4123.513 of the Revised Code that may be subsequently reimbursed by the administrator of workers' compensation or a self-insuring employer under that section, or payments made pursuant to cost sharing agreements under comprehensive sickness and accident plans. An "eligible medical expense" does not include expenses otherwise paid or reimbursed, including medical expenses paid or reimbursed under an automobile or motor vehicle insurance policy, a workers' compensation insurance policy or plan administered by the federal government or another state, or an employer-sponsored health coverage policy, plan, or contract.

(C) "Dependent" has the same meaning as in section 152 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

Sec. 4121.01. (A) As used in sections 4121.01 to 4121.29 of the Revised Code:

(1) "Place of employment" means every place, whether indoors or out, or underground, and the premises appurtenant thereto, where either temporarily or permanently any industry, trade, or

business is carried on, or where any process or operation, directly or indirectly related to any industry, trade, or business, is carried on and where any person is directly or indirectly employed by another for direct or indirect gain or profit, but does not include any place where persons are employed in private domestic service or agricultural pursuits which do not involve the use of mechanical power.

(2) "Employment" means any trade, occupation, or process of manufacture or any method of carrying on such trade, occupation, or process of manufacture in which any person may be engaged, except in such private domestic service or agricultural pursuits as do not involve the use of mechanical power.

(3) "Employer" means every person, firm, corporation, agent, manager, representative, or other person having control or custody of any employment, place of employment, or employee.

(4) "Employee" means every person who may be required or directed by any employer, in consideration of direct or indirect gain or profit, to engage in any employment, or to go, or work, or be at any time in any place of employment.

(5) "Frequenter" means every person, other than an employee, who may go in or be in a place of employment under circumstances which render the person other than a trespasser.

(6) "Deputy" means any person employed by the industrial commission or the bureau of workers' compensation, designated as a deputy by the commission or the administrator of workers' compensation, who possesses special, technical, scientific, managerial, professional, or personal abilities or qualities in matters within the jurisdiction of the commission or the bureau, and who may be engaged in the performance of duties under the direction of the commission or the bureau calling for the exercise of such abilities or qualities.

(7) "Order" means any decision, rule, regulation, direction, requirement, or standard, or any other determination or decision that the bureau is empowered to and does make.

(8) "General order" means an order that applies generally throughout the state to all persons, employments, or places of employment, or all persons, employments, or places of employment of a class under the jurisdiction of the bureau. All other orders shall be considered special orders.

(9) "Local order" means any ordinance, order, rule, or determination of the legislative authority of any municipal corporation, or any trustees, or board or officers of any municipal corporation upon any matter over which the bureau has jurisdiction.

(10) "Welfare" means comfort, decency, and moral well-being.

(11) "Safe" or "safety," as applied to any employment or a place of employment, means such freedom from danger to the life, health, safety, or welfare of employees or frequenters as the nature of the employment will reasonably permit, including requirements as to the hours of labor with relation to the health and welfare of employees.

(12) "Health insurance" means any of the following:

(a) A policy, contract, or agreement entered into between a subscriber and a health insuring corporation under Chapter 1751. of the Revised Code.

(b) A policy of sickness and accident insurance delivered, issued for delivery, renewed, or used pursuant to Chapter 3923. of the Revised Code.

(c) A high deductible health plan.

(13) "Health insurer" means a health insuring corporation holding a certificate of authority under Chapter 1751. of the

Revised Code or an insurance company holding a certificate of authority issued under Title XXXIX of the Revised Code.

(14) "Subscriber" has the same meaning as in section 1751.01 of the Revised Code.

(15) "High deductible health plan" includes either of the following:

(a) A plan defined under section 223(c)(2) of the "Internal Revenue Code of 1986," 26 U.S.C. 223, as amended.

(b) A plan defined under section 220(c)(2) of the "Internal Revenue Code of 1986," 26 U.S.C. 223, as amended.

(B) As used in the Revised Code:

(1) "Industrial commission" means the chairperson of the three-member industrial commission created pursuant to section 4121.02 of the Revised Code when the context refers to the authority vested in the chairperson as the chief executive officer of the three-member industrial commission pursuant to divisions (A), (B), (C), and (D) of section 4121.03 of the Revised Code.

(2) "Industrial commission" means the three-member industrial commission created pursuant to section 4121.02 of the Revised Code when the context refers to the authority vested in the three-member industrial commission pursuant to division (E) of section 4121.03 of the Revised Code.

(3) "Industrial commission" means the industrial commission as a state agency when the context refers to the authority vested in the industrial commission as a state agency.

Sec. 4121.44. (A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code.

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau of workers' compensation as set forth in section 4121.441 of the Revised Code. To implement the health partnership program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify external vendors for additional periods of two years; and

(3) May integrate the certified vendors with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section.

(C) Any vendor selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a substantial number of the medical, professional and pharmacy providers currently being utilized by claimants.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the vendor's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a

statewide basis have access to the eligibility and pricing, at a discounted rate, of all prescription drugs.

(5) A tracking system to record all telephone calls from claimants and providers regarding the status of submitted medical bills so as to be able to track each inquiry.

(6) Data processing capacity to absorb all of the bureau's medical bill processing or at least that part of the processing which the bureau arranges to delegate.

(7) Capacity to store, retrieve, array, simulate, and model in a relational mode all of the detailed medical bill data so that analysis can be performed in a variety of ways and so that the bureau and its governing authority can make informed decisions.

(8) Wide variety of software programs which translate medical terminology into standard codes, and which reveal if a provider is manipulating the procedures codes, commonly called "unbundling."

(9) Necessary professional staff to conduct, at a minimum, authorizations for treatment, medical necessity, utilization review, concurrent review, post-utilization review, and have the attendant computer system which supports such activity and measures the outcomes and the savings.

(10) Management experience and flexibility to be able to react quickly to the needs of the bureau in the case of required change in federal or state requirements.

(D)(1) Information contained in a vendor's application for certification in the health partnership program, and other information furnished to the bureau by a vendor for purposes of obtaining certification or to comply with performance and financial auditing requirements established by the administrator, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public or be used in any court in any proceeding pending therein,

unless the bureau is a party to the action or proceeding, but the information may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No employee of the bureau, except as otherwise authorized by the administrator, shall divulge any information secured by the employee while in the employ of the bureau in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person other than the administrator or to the employee's superior.

(2) Notwithstanding the restrictions imposed by division (D)(1) of this section, the governor, members of select or standing committees of the senate or house of representatives, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4123. of the Revised Code, may examine any vendor application or other information furnished to the bureau by the vendor. None of those individuals shall divulge any information secured in the exercise of that authority in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person.

(E) On and after January 1, 2001, a vendor shall not be any insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code.

(F) ~~The administrator may limit freedom of choice of health care provider or supplier by requiring, beginning with the period set forth in division (B)(1) or (2) of this section, that claimants shall pay an appropriate out-of-plan copayment for selecting a medical provider not within the health partnership program as provided for in this section.~~

~~(G)~~ The administrator, six months prior to the expiration of the bureau's certification or recertification of the vendor or vendors as set forth in division (B)(1) or (2) of this section, may certify and provide evidence to the governor, the speaker of the house of representatives, and the president of the senate that the existing bureau staff is able to match or exceed the performance and outcomes of the external vendor or vendors and that the bureau should be permitted to internally administer the health partnership program upon the expiration of the certification or recertification as set forth in division (B)(1) or (2) of this section.

~~(H)~~(G) The administrator shall establish and operate a bureau of workers' compensation health care data program. The administrator shall develop reporting requirements from all employees, employers and medical providers, medical vendors, and plans that participate in the workers' compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the selected vendor or vendors and to measure the outcomes and savings of the health partnership program.

(3) Publish and report compiled data to the governor, the speaker of the house of representatives, and the president of the senate on the first day of each January and July, the measures of outcomes and savings of the health partnership program. The administrator shall protect the confidentiality of all proprietary pricing data.

~~(I)~~(H) Any rehabilitation facility the bureau operates is

eligible for inclusion in the Ohio workers' compensation qualified health plan system or the health partnership program under the same terms as other providers within health care plans or the program.

~~(J) In areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code on a fee schedule the administrator adopts.~~

~~(K)~~(I) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan, except that a health care provider may charge or assess an employee a copayment or deductible in accordance with section 4123.513 of the Revised Code.

~~(L)~~(J) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this section and sections 4121.441 and 4121.442 of the Revised Code to provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code through qualified health plans of the Ohio workers' compensation qualified health plan system pursuant to section 4121.442 of the Revised Code or through the health partnership program pursuant to section 4121.441 of the Revised Code. No amount paid under the qualified health plan system pursuant to section 4121.442 of the

Revised Code by an employer who is a state fund employer shall be charged to the employer's experience or otherwise be used in merit-rating or determining the risk of that employer for the purpose of the payment of premiums under this chapter, and if the employer is a self-insuring employer, the employer shall not include that amount in the paid compensation the employer reports under section 4123.35 of the Revised Code.

Sec. 4121.441. (A) The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, shall adopt rules under Chapter 119. of the Revised Code for the health care partnership program administered by the bureau of workers' compensation to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

The rules shall include, but are not limited to, the following:

(1) Procedures for the resolution of medical disputes between an employer and an employee, an employee and a provider, or an employer and a provider, prior to an appeal under section 4123.511 of the Revised Code. Rules the administrator adopts pursuant to division (A)(1) of this section may specify that the resolution procedures shall not be used to resolve disputes concerning medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines.

(2) Prohibitions against discrimination against any category of health care providers;

(3) Procedures for reporting injuries to employers and the bureau by providers;

(4) Appropriate financial incentives to reduce service cost and insure proper system utilization without sacrificing the quality of service;

(5) Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment;

(6) A timely and accurate method of collection of necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the program;

(7) Provisions for necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not part of the program;

(8) Discounted pricing for all in-patient and out-patient medical services, all professional services, and all pharmaceutical services;

(9) Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost management techniques;

(10) Antifraud mechanisms;

(11) Standards and criteria for the bureau to utilize in certifying or recertifying a health care provider or a vendor for participation in the health partnership program;

(12) Standards and criteria for the bureau to utilize in penalizing or decertifying a health care provider or a vendor from participation in the health partnership program;

(13) Methods to coordinate benefits provided by a health care provider when a health insurer or employee is paying the bills incurred in a claim pursuant to section 4123.513 of the Revised

Code and prior to a final determination of the employee's eligibility to receive workers' compensation benefits under section 4123.511 or 4123.512 of the Revised Code;

(14) Methods to determine the amount a health insurer or employee shall pay a health care provider for medical bills incurred in the employee's claim prior to a final determination of the employee's eligibility to receive workers' compensation benefits under section 4123.511 or 4123.512 of the Revised Code;

(15) Methods to determine the amount a health care provider shall be paid after a final determination has been made concerning an employee's eligibility to receive compensation and benefits under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code;

(16) Methods to determine the amount the bureau shall reimburse a health insurer or employee for payment of medical bills for a claim after a final determination has been made that the employee is eligible to receive compensation and benefits under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

(B) The administrator shall implement the health partnership program according to the rules the administrator adopts under this section for the provision and payment of medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

Sec. 4121.442. (A) The administrator of workers' compensation shall develop standards for qualification of health care plans of the Ohio workers' compensation qualified health plan system to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury

or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code. In adopting the standards, the administrator shall use nationally recognized accreditation standards. The standards the administrator adopts must provide that a qualified plan provides for all of the following:

(1) Criteria for selective contracting of health care providers;

(2) Adequate plan structure and financial stability;

(3) Procedures for the resolution of medical disputes between an employee and an employer, an employee and a provider, or an employer and a provider, prior to an appeal under section 4123.511 of the Revised Code;

(4) Authorize employees who are dissatisfied with the health care services of the employer's qualified plan and do not wish to obtain treatment under the provisions of this section, to request the administrator for referral to a health care provider in the bureau's health care partnership program. The administrator must refer all requesting employees into the health care partnership program.

(5) Authorize employees to select a health care provider who is not included in the employer's qualified plan if the employee is receiving services from that health care provider pursuant to section 4123.513 of the Revised Code.

(6) Does not discriminate against any category of health care provider;

~~(6)~~(7) Provide a procedure for reporting injuries to the bureau of workers' compensation and to employers by providers within the qualified plan;

~~(7)~~(8) Provide appropriate financial incentives to reduce

service costs and utilization without sacrificing the quality of service;

~~(8)~~(9) Provide adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent and provide sanctions for inappropriate, excessive, or not medically necessary treatment;

~~(9)~~(10) Provide a timely and accurate method of reporting to the administrator necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the plan;

~~(10)~~(11) Authorize necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not a part of the qualified health care plan;

~~(11)~~(12) Provide an employee the right to change health care providers within the qualified health care plan;

~~(12)~~(13) Provide for standardized data and reporting requirements;

~~(13)~~(14) Authorize necessary medical treatment for employees who work in Ohio but reside in another state;

(15) Establish methods to coordinate benefits provided by a health care provider when a health insurer or employee is paying the bills incurred in a claim pursuant to section 4123.513 of the Revised Code and prior to a final determination of the employee's eligibility to receive workers' compensation benefits under section 4123.511 or 4123.512 of the Revised Code;

(16) Establish methods to determine the amount a health insurer or employee shall pay a health care provider for medical bills incurred in the employee's claim prior to a final determination of the employee's eligibility to receive workers'

compensation benefits under section 4123.511 or 4123.512 of the Revised Code;

(17) Establish methods to determine the amount a health care provider shall be paid after a final determination has been made, concerning an employee's eligibility to receive compensation and benefits under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code;

(18) Establish methods to determine the amount the bureau shall reimburse a health insurer or employee for payment of medical bills for a claim after a final determination has been made that the employee is eligible to receive compensation and benefits under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

(B) Health care plans that meet the approved qualified health plan standards shall be considered qualified plans and are eligible to become part of the Ohio workers' compensation qualified health plan system. Any employer or group of employers may provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code through a qualified health plan.

Sec. 4123.01. As used in this chapter:

(A)(1) "Employee" means:

(a) Every person in the service of the state, or of any county, municipal corporation, township, or school district therein, including regular members of lawfully constituted police and fire departments of municipal corporations and townships, whether paid or volunteer, and wherever serving within the state or on temporary assignment outside thereof, and executive officers

of boards of education, under any appointment or contract of hire, express or implied, oral or written, including any elected official of the state, or of any county, municipal corporation, or township, or members of boards of education.

As used in division (A)(1)(a) of this section, the term "employee" includes the following persons when responding to an inherently dangerous situation that calls for an immediate response on the part of the person, regardless of whether the person is within the limits of the jurisdiction of the person's regular employment or voluntary service when responding, on the condition that the person responds to the situation as the person otherwise would if the person were on duty in the person's jurisdiction:

(i) Off-duty peace officers. As used in division (A)(1)(a)(i) of this section, "peace officer" has the same meaning as in section 2935.01 of the Revised Code.

(ii) Off-duty firefighters, whether paid or volunteer, of a lawfully constituted fire department.

(iii) Off-duty first responders, emergency medical technicians-basic, emergency medical technicians-intermediate, or emergency medical technicians-paramedic, whether paid or volunteer, of an ambulance service organization or emergency medical service organization pursuant to Chapter 4765. of the Revised Code.

(b) Every person in the service of any person, firm, or private corporation, including any public service corporation, that (i) employs one or more persons regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, including aliens and minors, household workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single household and

casual workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single employer, or (ii) is bound by any such contract of hire or by any other written contract, to pay into the state insurance fund the premiums provided by this chapter.

(c) Every person who performs labor or provides services pursuant to a construction contract, as defined in section 4123.79 of the Revised Code, if at least ten of the following criteria apply:

(i) The person is required to comply with instructions from the other contracting party regarding the manner or method of performing services;

(ii) The person is required by the other contracting party to have particular training;

(iii) The person's services are integrated into the regular functioning of the other contracting party;

(iv) The person is required to perform the work personally;

(v) The person is hired, supervised, or paid by the other contracting party;

(vi) A continuing relationship exists between the person and the other contracting party that contemplates continuing or recurring work even if the work is not full time;

(vii) The person's hours of work are established by the other contracting party;

(viii) The person is required to devote full time to the business of the other contracting party;

(ix) The person is required to perform the work on the premises of the other contracting party;

(x) The person is required to follow the order of work set by the other contracting party;

(xi) The person is required to make oral or written reports of progress to the other contracting party;

(xii) The person is paid for services on a regular basis such as hourly, weekly, or monthly;

(xiii) The person's expenses are paid for by the other contracting party;

(xiv) The person's tools and materials are furnished by the other contracting party;

(xv) The person is provided with the facilities used to perform services;

(xvi) The person does not realize a profit or suffer a loss as a result of the services provided;

(xvii) The person is not performing services for a number of employers at the same time;

(xviii) The person does not make the same services available to the general public;

(xix) The other contracting party has a right to discharge the person;

(xx) The person has the right to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement.

Every person in the service of any independent contractor or subcontractor who has failed to pay into the state insurance fund the amount of premium determined and fixed by the administrator of workers' compensation for the person's employment or occupation or if a self-insuring employer has failed to pay compensation and benefits directly to the employer's injured and to the dependents of the employer's killed employees as required by section 4123.35 of the Revised Code or to reimburse directly a health insurer or employee pursuant to section 4123.513 of the Revised Code, shall

be considered as the employee of the person who has entered into a contract, whether written or verbal, with such independent contractor unless such employees or their legal representatives or beneficiaries elect, after injury or death, to regard such independent contractor as the employer.

(2) "Employee" does not mean:

(a) A duly ordained, commissioned, or licensed minister or assistant or associate minister of a church in the exercise of ministry;

(b) Any officer of a family farm corporation;

(c) An individual incorporated as a corporation; or

(d) An individual who otherwise is an employee of an employer but who signs the waiver and affidavit specified in section 4123.15 of the Revised Code on the condition that the administrator has granted a waiver and exception to the individual's employer under section 4123.15 of the Revised Code.

Any employer may elect to include as an "employee" within this chapter, any person excluded from the definition of "employee" pursuant to division (A)(2) of this section. If an employer is a partnership, sole proprietorship, individual incorporated as a corporation, or family farm corporation, such employer may elect to include as an "employee" within this chapter, any member of such partnership, the owner of the sole proprietorship, the individual incorporated as a corporation, or the officers of the family farm corporation. In the event of an election, the employer shall serve upon the bureau of workers' compensation written notice naming the persons to be covered, include such employee's remuneration for premium purposes in all future payroll reports, and no person excluded from the definition of "employee" pursuant to division (A)(2) of this section, proprietor, individual incorporated as a corporation, or partner

shall be deemed an employee within this division until the employer has served such notice.

For informational purposes only, the bureau shall prescribe such language as it considers appropriate, on such of its forms as it considers appropriate, to advise employers of their right to elect to include as an "employee" within this chapter a sole proprietor, any member of a partnership, an individual incorporated as a corporation, the officers of a family farm corporation, or a person excluded from the definition of "employee" under division (A)(2) of this section, that they should check any health and disability insurance policy, or other form of health and disability plan or contract, presently covering them, or the purchase of which they may be considering, to determine whether such policy, plan, or contract excludes benefits for illness or injury that they might have elected to have covered by workers' compensation.

(B) "Employer" means:

(1) The state, including state hospitals, each county, municipal corporation, township, school district, and hospital owned by a political subdivision or subdivisions other than the state;

(2) Every person, firm, professional employer organization as defined in section 4125.01 of the Revised Code, and private corporation, including any public service corporation, that (a) has in service one or more employees or shared employees regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, or (b) is bound by any such contract of hire or by any other written contract, to pay into the insurance fund the premiums provided by this chapter.

All such employers are subject to this chapter. Any member of

a firm or association, who regularly performs manual labor in or about a mine, factory, or other establishment, including a household establishment, shall be considered an employee in determining whether such person, firm, or private corporation, or public service corporation, has in its service, one or more employees and the employer shall report the income derived from such labor to the bureau as part of the payroll of such employer, and such member shall thereupon be entitled to all the benefits of an employee.

(C) "Injury" includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. "Injury" does not include:

(1) Psychiatric conditions except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate;

(2) Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of the body;

(3) Injury or disability incurred in voluntary participation in an employer-sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreation or fitness activity;

(4) A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury. Such a substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of such a

substantial aggravation. However, subjective complaints without objective diagnostic findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation.

(D) "Child" includes a posthumous child and a child legally adopted prior to the injury.

(E) "Family farm corporation" means a corporation founded for the purpose of farming agricultural land in which the majority of the voting stock is held by and the majority of the stockholders are persons or the spouse of persons related to each other within the fourth degree of kinship, according to the rules of the civil law, and at least one of the related persons is residing on or actively operating the farm, and none of whose stockholders are a corporation. A family farm corporation does not cease to qualify under this division where, by reason of any devise, bequest, or the operation of the laws of descent or distribution, the ownership of shares of voting stock is transferred to another person, as long as that person is within the degree of kinship stipulated in this division.

(F) "Occupational disease" means a disease contracted in the course of employment, which by its causes and the characteristics of its manifestation or the condition of the employment results in a hazard which distinguishes the employment in character from employment generally, and the employment creates a risk of contracting the disease in greater degree and in a different manner from the public in general.

(G) "Self-insuring employer" means an employer who is granted the privilege of paying compensation and benefits directly under section 4123.35 of the Revised Code, including a board of county commissioners for the sole purpose of constructing a sports facility as defined in section 307.696 of the Revised Code, provided that the electors of the county in which the sports

facility is to be built have approved construction of a sports facility by ballot election no later than November 6, 1997.

(H) "Public employer" means an employer as defined in division (B)(1) of this section.

(I) "Sexual conduct" means vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of gender; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal cavity of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.

(J) "Health insurance," "health insurer," "subscriber," and "high deductible health plan" have the same meanings as in section 4121.01 of the Revised Code.

Sec. 4123.30. Money contributed by the employers mentioned in division (B)(1) of section 4123.01 of the Revised Code constitutes the "public fund" and the money contributed by employers mentioned in division (B)(2) of such section constitutes the "private fund." Each such fund shall be collected, distributed, and its solvency maintained without regard to or reliance upon the other. Whenever in this chapter reference is made to the state insurance fund, the reference is to such two separate funds but such two separate funds and the net premiums contributed thereto by employers after adjustments and dividends, except for the amount thereof which is set aside for the investigation and prevention of industrial accidents and diseases pursuant to Section 35 of Article II, Ohio Constitution, any amounts set aside for actuarial services authorized or required by sections 4123.44 and 4123.47 of the Revised Code, and any amounts set aside to reinsure the liability of the respective insurance funds for the following payments, constitute a trust fund for the benefit of employers and employees

mentioned in sections 4123.01, 4123.03, and 4123.73 of the Revised Code for the payment of compensation, medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, rehabilitation, death benefits, funeral expenses, and like benefits for loss sustained on account of injury, disease, or death provided for by this chapter, for reimbursements to health insurers and employees for bills for medical benefits that the health insurer or employee paid pursuant to section 4123.513 of the Revised Code, and for no other purpose. This section does not prevent the deposit or investment of all such moneys intermingled for such purpose but such funds shall be separate and distinct for all other purposes, and the rights and duties created in this chapter shall be construed to have been made with respect to two separate funds and so as to maintain and continue such funds separately except for deposit or investment. Disbursements shall not be made on account of injury, disease, or death of employees of employers who contribute to one of such funds unless the moneys to the credit of such fund are sufficient therefor and no such disbursements shall be made for moneys or credits paid or credited to the other fund.

Sec. 4123.343. This section shall be construed liberally to the end that employers shall be encouraged to employ and retain in their employment handicapped employees as defined in this section.

(A) As used in this section, "handicapped employee" means an employee who is afflicted with or subject to any physical or mental impairment, or both, whether congenital or due to an injury or disease of such character that the impairment constitutes a handicap in obtaining employment or would constitute a handicap in obtaining reemployment if the employee should become unemployed and whose handicap is due to any of the following diseases or conditions:

(1) Epilepsy;

(2) Diabetes;

(3) Cardiac disease;

(4) Arthritis;

(5) Amputated foot, leg, arm, or hand;

(6) Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than seventy-five per cent bilaterally;

(7) Residual disability from poliomyelitis;

(8) Cerebral palsy;

(9) Multiple sclerosis;

(10) Parkinson's disease;

(11) Cerebral vascular accident;

(12) Tuberculosis;

(13) Silicosis;

(14) Psycho-neurotic disability following treatment in a recognized medical or mental institution;

(15) Hemophilia;

(16) Chronic osteomyelitis;

(17) Ankylosis of joints;

(18) Hyper insulinism;

(19) Muscular dystrophies;

(20) Arterio-sclerosis;

(21) Thrombo-phlebitis;

(22) Varicose veins;

(23) Cardiovascular, pulmonary, or respiratory diseases of a firefighter or police officer employed by a municipal corporation

or township as a regular member of a lawfully constituted police department or fire department;

(24) Coal miners' pneumoconiosis, commonly referred to as "black lung disease";

(25) Disability with respect to which an individual has completed a rehabilitation program conducted pursuant to sections 4121.61 to 4121.69 of the Revised Code.

(B) Under the circumstances set forth in this section all or such portion as the administrator determines of the compensation and benefits paid in any claim arising hereafter shall be charged to and paid from the statutory surplus fund created under section 4123.34 of the Revised Code and only the portion remaining shall be merit-rated or otherwise treated as part of the accident or occupational disease experience of the employer. If the employer is a self-insuring employer, the proportion of such costs whether charged to the statutory surplus fund in whole or in part shall be by way of ~~direct~~ payment to such employee, the employee's health insurer, or the employee's dependents or by way of reimbursement to the self-insuring employer as the circumstances indicate. The provisions of this section apply only in cases of death, total disability, whether temporary or permanent, and all disabilities compensated under division (B) of section 4123.57 of the Revised Code. The administrator shall adopt rules specifying the grounds upon which charges to the statutory surplus fund are to be made. The rules shall prohibit as a grounds any agreement between employer and claimant as to the merits of a claim and the amount of the charge.

(C) Any employer who has in its employ a handicapped employee is entitled, in the event the person is injured, to a determination under this section.

An employer shall file an application under this section for

a determination with the bureau or commission in the same manner as other claims. An application only may be made in cases where a handicapped employee or a handicapped employee's dependents claim or ~~is~~ are receiving an award of compensation as a result of an injury or occupational disease occurring or contracted on or after the date on which division (A) of this section first included the handicap of such employee.

(D) The circumstances under and the manner in which an apportionment under this section shall be made are:

(1) Whenever a handicapped employee is injured or disabled or dies as the result of an injury or occupational disease sustained in the course of and arising out of a handicapped employee's employment in this state and the administrator awards compensation therefor and when it appears to the satisfaction of the administrator that the injury or occupational disease or the death resulting therefrom would not have occurred but for the pre-existing physical or mental impairment of the handicapped employee, all compensation and benefits payable on account of the disability or death shall be paid from the surplus fund.

(2) Whenever a handicapped employee is injured or disabled or dies as a result of an injury or occupational disease and the administrator finds that the injury or occupational disease would have been sustained or suffered without regard to the employee's pre-existing impairment but that the resulting disability or death was caused at least in part through aggravation of the employee's pre-existing disability, the administrator shall determine in a manner that is equitable and reasonable and based upon medical evidence the amount of disability or proportion of the cost of the death award that is attributable to the employee's pre-existing disability and the amount found shall be charged to the statutory surplus fund.

(E) The benefits and provisions of this section apply only to

employers who have complied with this chapter either through insurance with the state fund or as a self-insuring employer.

(F) No employer shall in any year receive credit under this section in an amount greater than the premium the employer paid if a state fund employer or greater than the employer's assessments if a self-insuring employer.

(G) Self-insuring employers may, for all claims made after January 1, 1987, for compensation and benefits under this section, pay the compensation and benefits directly to the employee or the employee's dependents, or directly reimburse a health insurer pursuant to section 4123.513 of the Revised Code. If such an employer chooses to pay compensation and benefits directly, the employer shall receive no money or credit from the surplus fund for the payment under this section, nor shall the employer be required to pay any amounts into the surplus fund that otherwise would be assessed for handicapped reimbursements for claims made after January 1, 1987. Where a self-insuring employer elects to pay for compensation and benefits pursuant to this section, the employer shall assume responsibility for compensation and benefits arising out of claims made prior to January 1, 1987, and shall not be required to pay any amounts into the surplus fund and may not receive any money or credit from that fund on account of this section. The election made under this division is irrevocable.

(H) An order issued by the administrator pursuant to this section is appealable under section 4123.511 of the Revised Code but is not appealable to court under section 4123.512 of the Revised Code.

Sec. 4123.35. (A) Except as provided in this section, every employer mentioned in division (B)(2) of section 4123.01 of the Revised Code, and every publicly owned utility shall pay semiannually in the months of January and July into the state

insurance fund the amount of annual premium the administrator of workers' compensation fixes for the employment or occupation of the employer, the amount of which premium to be paid by each employer to be determined by the classifications, rules, and rates made and published by the administrator. The employer shall pay semiannually a further sum of money into the state insurance fund as may be ascertained to be due from the employer by applying the rules of the administrator, and a receipt or certificate certifying that payment has been made, along with a written notice as is required in section 4123.54 of the Revised Code, shall be mailed immediately to the employer by the bureau of workers' compensation. The receipt or certificate is prima-facie evidence of the payment of the premium, and the proper posting of the notice constitutes the employer's compliance with the notice requirement mandated in section 4123.54 of the Revised Code.

The bureau of workers' compensation shall verify with the secretary of state the existence of all corporations and organizations making application for workers' compensation coverage and shall require every such application to include the employer's federal identification number.

An employer as defined in division (B)(2) of section 4123.01 of the Revised Code who has contracted with a subcontractor is liable for the unpaid premium due from any subcontractor with respect to that part of the payroll of the subcontractor that is for work performed pursuant to the contract with the employer.

Division (A) of this section providing for the payment of premiums semiannually does not apply to any employer who was a subscriber to the state insurance fund prior to January 1, 1914, or who may first become a subscriber to the fund in any month other than January or July. Instead, the semiannual premiums shall be paid by those employers from time to time upon the expiration of the respective periods for which payments into the fund have

been made by them.

The administrator shall adopt rules to permit employers to make periodic payments of the semiannual premium due under this division. The rules shall include provisions for the assessment of interest charges, where appropriate, and for the assessment of penalties when an employer fails to make timely premium payments. An employer who timely pays the amounts due under this division is entitled to all of the benefits and protections of this chapter. Upon receipt of payment, the bureau immediately shall mail a receipt or certificate to the employer certifying that payment has been made, which receipt is prima-facie evidence of payment. Workers' compensation coverage under this chapter continues uninterrupted upon timely receipt of payment under this division.

Every public employer, except public employers that are self-insuring employers under this section, shall comply with sections 4123.38 to 4123.41, and 4123.48 of the Revised Code in regard to the contribution of moneys to the public insurance fund.

(B) Employers who will abide by the rules of the administrator and who may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code, and who do not desire to insure the payment thereof or indemnify themselves against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, or to reimburse a health insurer or an employee who paid a health care provider for

medical benefits provided by that health care provider, pursuant to section 4123.513 of the Revised Code, thereby being granted status as a self-insuring employer. The administrator may charge employers who apply for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application.

All employers granted status as self-insuring employers shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section.

(1) The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the employer by this section:

(a) The employer employs a minimum of five hundred employees in this state;

(b) The employer has operated in this state for a minimum of two years, provided that an employer who has purchased, acquired, or otherwise succeeded to the operation of a business, or any part thereof, situated in this state that has operated for at least two years in this state, also shall qualify;

(c) Where the employer previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;

(d) The sufficiency of the employer's assets located in this state to insure the employer's solvency in paying compensation directly;

(e) The financial records, documents, and data, certified by

a certified public accountant, necessary to provide the employer's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.

(f) The employer's organizational plan for the administration of the workers' compensation law;

(g) The employer's proposed plan to inform employees of the change from a state fund insurer to a self-insuring employer, the procedures the employer will follow as a self-insuring employer, and the employees' rights to compensation and benefits; and

(h) The employer has either an account in a financial institution in this state, or if the employer maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the employer clearly indicates that payment will be honored by a financial institution in this state.

The administrator may waive the requirements of divisions (B)(1)(a) and (b) of this section and the requirement of division (B)(1)(e) of this section that the financial records, documents, and data be certified by a certified public accountant. The administrator shall adopt rules establishing the criteria that an employer shall meet in order for the administrator to waive the requirement of division (B)(1)(e) of this section. Such rules may require additional security of that employer pursuant to division (E) of section 4123.351 of the Revised Code.

The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education, excluding its hospitals, that meets the requirements of division (B)(2) of this section.

(2) When considering the application of a public employer,

except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, the administrator shall verify that the public employer satisfies all of the following requirements as the requirements apply to that public employer:

(a) For the two-year period preceding application under this section, the public employer has maintained an unvoted debt capacity equal to at least two times the amount of the current annual premium established by the administrator under this chapter for that public employer for the year immediately preceding the year in which the public employer makes application under this section.

(b) For each of the two fiscal years preceding application under this section, the unreserved and undesignated year-end fund balance in the public employer's general fund is equal to at least five per cent of the public employer's general fund revenues for the fiscal year computed in accordance with generally accepted accounting principles.

(c) For the five-year period preceding application under this section, the public employer, to the extent applicable, has complied fully with the continuing disclosure requirements established in rules adopted by the United States securities and exchange commission under 17 C.F.R. 240.15c 2-12.

(d) For the five-year period preceding application under this section, the public employer has not had its local government fund distribution withheld on account of the public employer being indebted or otherwise obligated to the state.

(e) For the five-year period preceding application under this section, the public employer has not been under a fiscal watch or fiscal emergency pursuant to section 118.023, 118.04, or 3316.03 of the Revised Code.

(f) For the public employer's fiscal year preceding application under this section, the public employer has obtained an annual financial audit as required under section 117.10 of the Revised Code, which has been released by the auditor of state within seven months after the end of the public employer's fiscal year.

(g) On the date of application, the public employer holds a debt rating of Aa3 or higher according to Moody's investors service, inc., or a comparable rating by an independent rating agency similar to Moody's investors service, inc.

(h) The public employer agrees to generate an annual accumulating book reserve in its financial statements reflecting an actuarially generated reserve adequate to pay projected claims under this chapter for the applicable period of time, as determined by the administrator.

(i) For a public employer that is a hospital, the public employer shall submit audited financial statements showing the hospital's overall liquidity characteristics, and the administrator shall determine, on an individual basis, whether the public employer satisfies liquidity standards equivalent to the liquidity standards of other public employers.

(j) Any additional criteria that the administrator adopts by rule pursuant to division (E) of this section.

The administrator shall not approve the application of a public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or publicly owned utility, who does not satisfy all of the requirements listed in division (B)(2) of this section.

(C) A board of county commissioners described in division (G) of section 4123.01 of the Revised Code, as an employer, that will

abide by the rules of the administrator and that may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code, and that does not desire to insure the payment thereof or indemnify itself against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, or to reimburse a health insurer or an employee who paid a health care provider for medical benefits provided by that health care provider, pursuant to section 4123.513 of the Revised Code, thereby being granted status as a self-insuring employer. The administrator may charge a board of county commissioners described in division (G) of section 4123.01 of the Revised Code that applies for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application. All employers granted such status shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section. The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the board as an employer by this section:

(1) The board as an employer employs a minimum of five

hundred employees in this state;

(2) The board has operated in this state for a minimum of two years;

(3) Where the board previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;

(4) The sufficiency of the board's assets located in this state to insure the board's solvency in paying compensation directly;

(5) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the board's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.

(6) The board's organizational plan for the administration of the workers' compensation law;

(7) The board's proposed plan to inform employees of the proposed self-insurance, the procedures the board will follow as a self-insuring employer, and the employees' rights to compensation and benefits;

(8) The board has either an account in a financial institution in this state, or if the board maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the board clearly indicates that payment will be honored by a financial institution in this state;

(9) The board shall provide the administrator a surety bond in an amount equal to one hundred twenty-five per cent of the projected losses as determined by the administrator.

(D) The administrator shall require a surety bond from all

self-insuring employers, issued pursuant to section 4123.351 of the Revised Code, that is sufficient to compel, or secure to injured employees, or to the dependents of employees killed, the payment of compensation and expenses and the reimbursement of health insurers and employees for the payment of medical benefits pursuant to section 4123.513 of the Revised Code, which shall in no event be less than that paid or furnished out of the state insurance fund in similar cases to injured employees or to dependents of killed employees whose employers contribute to the fund, except when an employee of the employer, who has suffered the loss of a hand, arm, foot, leg, or eye prior to the injury for which compensation is to be paid, and thereafter suffers the loss of any other of the members as the result of any injury sustained in the course of and arising out of the employee's employment, the compensation to be paid by the self-insuring employer is limited to the disability suffered in the subsequent injury, additional compensation, if any, to be paid by the bureau out of the surplus created by section 4123.34 of the Revised Code.

(E) In addition to the requirements of this section, the administrator shall make and publish rules governing the manner of making application and the nature and extent of the proof required to justify a finding of fact by the administrator as to granting the status of a self-insuring employer, which rules shall be general in their application, one of which rules shall provide that all self-insuring employers shall pay into the state insurance fund such amounts as are required to be credited to the surplus fund in division (B) of section 4123.34 of the Revised Code. The administrator may adopt rules establishing requirements in addition to the requirements described in division (B)(2) of this section that a public employer shall meet in order to qualify for self-insuring status.

Employers shall secure directly from the bureau central

offices application forms upon which the bureau shall stamp a designating number. Prior to submission of an application, an employer shall make available to the bureau, and the bureau shall review, the information described in division (B)(1) of this section, and public employers shall make available, and the bureau shall review, the information necessary to verify whether the public employer meets the requirements listed in division (B)(2) of this section. An employer shall file the completed application forms with an application fee, which shall cover the costs of processing the application, as established by the administrator, by rule, with the bureau at least ninety days prior to the effective date of the employer's new status as a self-insuring employer. The application form is not deemed complete until all the required information is attached thereto. The bureau shall only accept applications that contain the required information.

(F) The bureau shall review completed applications within a reasonable time. If the bureau determines to grant an employer the status as a self-insuring employer, the bureau shall issue a statement, containing its findings of fact, that is prepared by the bureau and signed by the administrator. If the bureau determines not to grant the status as a self-insuring employer, the bureau shall notify the employer of the determination and require the employer to continue to pay its full premium into the state insurance fund. The administrator also shall adopt rules establishing a minimum level of performance as a criterion for granting and maintaining the status as a self-insuring employer and fixing time limits beyond which failure of the self-insuring employer to provide for the necessary medical examinations and evaluations may not delay a decision on a claim.

(G) The administrator shall adopt rules setting forth procedures for auditing the program of self-insuring employers. The bureau shall conduct the audit upon a random basis or whenever

the bureau has grounds for believing that a self-insuring employer is not in full compliance with bureau rules or this chapter.

The administrator shall monitor the programs conducted by self-insuring employers, to ensure compliance with bureau requirements and for that purpose, shall develop and issue to self-insuring employers standardized forms for use by the self-insuring employer in all aspects of the self-insuring employers' direct compensation program and for reporting of information to the bureau.

The bureau shall receive and transmit to the self-insuring employer all complaints concerning any self-insuring employer. In the case of a complaint against a self-insuring employer, the administrator shall handle the complaint through the self-insurance division of the bureau. The bureau shall maintain a file by employer of all complaints received that relate to the employer. The bureau shall evaluate each complaint and take appropriate action.

The administrator shall adopt as a rule a prohibition against any self-insuring employer from harassing, dismissing, or otherwise disciplining any employee making a complaint, which rule shall provide for a financial penalty to be levied by the administrator payable by the offending self-insuring employer.

(H) For the purpose of making determinations as to whether to grant status as a self-insuring employer, the administrator may subscribe to and pay for a credit reporting service that offers financial and other business information about individual employers. The costs in connection with the bureau's subscription or individual reports from the service about an applicant may be included in the application fee charged employers under this section.

(I) The administrator, notwithstanding other provisions of

this chapter, may permit a self-insuring employer to resume payment of premiums to the state insurance fund with appropriate credit modifications to the employer's basic premium rate as such rate is determined pursuant to section 4123.29 of the Revised Code.

(J) On the first day of July of each year, the administrator shall calculate separately each self-insuring employer's assessments for the safety and hygiene fund, administrative costs pursuant to section 4123.342 of the Revised Code, and for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is not used for handicapped reimbursement, on the basis of the paid compensation attributable to the individual self-insuring employer according to the following calculation:

(1) The total assessment against all self-insuring employers as a class for each fund and for the administrative costs for the year that the assessment is being made, as determined by the administrator, divided by the total amount of paid compensation for the previous calendar year attributable to all amenable self-insuring employers;

(2) Multiply the quotient in division (J)(1) of this section by the total amount of paid compensation for the previous calendar year that is attributable to the individual self-insuring employer for whom the assessment is being determined. Each self-insuring employer shall pay the assessment that results from this calculation, unless the assessment resulting from this calculation falls below a minimum assessment, which minimum assessment the administrator shall determine on the first day of July of each year with the advice and consent of the workers' compensation oversight commission, in which event, the self-insuring employer shall pay the minimum assessment.

In determining the total amount due for the total assessment

against all self-insuring employers as a class for each fund and the administrative assessment, the administrator shall reduce proportionately the total for each fund and assessment by the amount of money in the self-insurance assessment fund as of the date of the computation of the assessment.

The administrator shall calculate the assessment for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is used for handicapped reimbursement in the same manner as set forth in divisions (J)(1) and (2) of this section except that the administrator shall calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers that retain participation in the handicapped reimbursement program and the individual self-insuring employer's proportion of paid compensation shall be calculated only for those self-insuring employers who retain participation in the handicapped reimbursement program. The administrator, as the administrator determines appropriate, may determine the total assessment for the handicapped portion of the surplus fund in accordance with sound actuarial principles.

The administrator shall calculate the assessment for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that under division (D) of section 4121.66 of the Revised Code is used for rehabilitation costs in the same manner as set forth in divisions (J)(1) and (2) of this section, except that the administrator shall calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers who have not made the election to make payments directly under division (D) of section 4121.66 of the Revised Code and an individual self-insuring employer's proportion of paid compensation only for those self-insuring employers who have not made that election.

The administrator shall calculate the assessment for the

portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is used for reimbursement to a self-insuring employer under division (H) of section 4123.512 of the Revised Code in the same manner as set forth in divisions (J)(1) and (2) of this section except that the administrator shall calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers that retain participation in reimbursement to the self-insuring employer under division (H) of section 4123.512 of the Revised Code and the individual self-insuring employer's proportion of paid compensation shall be calculated only for those self-insuring employers who retain participation in reimbursement to the self-insuring employer under division (H) of section 4123.512 of the Revised Code.

An employer who no longer is a self-insuring employer in this state or who no longer is operating in this state, shall continue to pay assessments for administrative costs and for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is not used for handicapped reimbursement, based upon paid compensation attributable to claims that occurred while the employer was a self-insuring employer within this state.

(K) There is hereby created in the state treasury the self-insurance assessment fund. All investment earnings of the fund shall be deposited in the fund. The administrator shall use the money in the self-insurance assessment fund only for administrative costs as specified in section 4123.341 of the Revised Code.

(L) Every self-insuring employer shall certify, in affidavit form subject to the penalty for perjury, to the bureau the amount of the self-insuring employer's paid compensation for the previous calendar year. In reporting paid compensation paid for the previous year, a self-insuring employer shall exclude from the

total amount of paid compensation any reimbursement the self-insuring employer receives in the previous calendar year from the surplus fund pursuant to section 4123.512 of the Revised Code for any paid compensation. The self-insuring employer also shall exclude from the paid compensation reported any amount recovered under section 4123.931 of the Revised Code and any amount that is determined not to have been payable to or on behalf of a claimant in any final administrative or judicial proceeding. The self-insuring employer shall exclude such amounts from the paid compensation reported in the reporting period subsequent to the date the determination is made. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, that provide for all of the following:

(1) Establishing the date by which self-insuring employers must submit such information and the amount of the assessments provided for in division (J) of this section for employers who have been granted self-insuring status within the last calendar year;

(2) If an employer fails to pay the assessment when due, the administrator may add a late fee penalty of not more than five hundred dollars to the assessment plus an additional penalty amount as follows:

(a) For an assessment from sixty-one to ninety days past due, the prime interest rate, multiplied by the assessment due;

(b) For an assessment from ninety-one to one hundred twenty days past due, the prime interest rate plus two per cent, multiplied by the assessment due;

(c) For an assessment from one hundred twenty-one to one hundred fifty days past due, the prime interest rate plus four per cent, multiplied by the assessment due;

(d) For an assessment from one hundred fifty-one to one

hundred eighty days past due, the prime interest rate plus six per cent, multiplied by the assessment due;

(e) For an assessment from one hundred eighty-one to two hundred ten days past due, the prime interest rate plus eight per cent, multiplied by the assessment due;

(f) For each additional thirty-day period or portion thereof that an assessment remains past due after it has remained past due for more than two hundred ten days, the prime interest rate plus eight per cent, multiplied by the assessment due.

(3) An employer may appeal a late fee penalty and penalty assessment to the administrator.

For purposes of this division, "prime interest rate" means the average bank prime rate, and the administrator shall determine the prime interest rate in the same manner as a county auditor determines the average bank prime rate under section 929.02 of the Revised Code.

The administrator shall include any assessment and penalties that remain unpaid for previous assessment periods in the calculation and collection of any assessments due under this division or division (J) of this section.

(M) As used in this section, "paid compensation" means all amounts paid by a self-insuring employer for living maintenance benefits, all amounts for compensation paid pursuant to sections 4121.63, 4121.67, 4123.56, 4123.57, 4123.58, 4123.59, 4123.60, and 4123.64 of the Revised Code, all amounts paid as wages in lieu of such compensation, all amounts paid in lieu of such compensation under a nonoccupational accident and sickness program fully funded by the self-insuring employer, and all amounts paid by a self-insuring employer for a violation of a specific safety standard pursuant to Section 35 of Article II, Ohio Constitution and section 4121.47 of the Revised Code.

(N) Should any section of this chapter or Chapter 4121. of the Revised Code providing for self-insuring employers' assessments based upon compensation paid be declared unconstitutional by a final decision of any court, then that section of the Revised Code declared unconstitutional shall revert back to the section in existence prior to November 3, 1989, providing for assessments based upon payroll.

(O) The administrator may grant a self-insuring employer the privilege to self-insure a construction project entered into by the self-insuring employer that is scheduled for completion within six years after the date the project begins, and the total cost of which is estimated to exceed one hundred million dollars or, for employers described in division (R) of this section, if the construction project is estimated to exceed twenty-five million dollars. The administrator may waive such cost and time criteria and grant a self-insuring employer the privilege to self-insure a construction project regardless of the time needed to complete the construction project and provided that the cost of the construction project is estimated to exceed fifty million dollars. A self-insuring employer who desires to self-insure a construction project shall submit to the administrator an application listing the dates the construction project is scheduled to begin and end, the estimated cost of the construction project, the contractors and subcontractors whose employees are to be self-insured by the self-insuring employer, the provisions of a safety program that is specifically designed for the construction project, and a statement as to whether a collective bargaining agreement governing the rights, duties, and obligations of each of the parties to the agreement with respect to the construction project exists between the self-insuring employer and a labor organization.

A self-insuring employer may apply to self-insure the

employees of either of the following:

(1) All contractors and subcontractors who perform labor or work or provide materials for the construction project;

(2) All contractors and, at the administrator's discretion, a substantial number of all the subcontractors who perform labor or work or provide materials for the construction project.

Upon approval of the application, the administrator shall mail a certificate granting the privilege to self-insure the construction project to the self-insuring employer. The certificate shall contain the name of the self-insuring employer and the name, address, and telephone number of the self-insuring employer's representatives who are responsible for administering workers' compensation claims for the construction project. The self-insuring employer shall post the certificate in a conspicuous place at the site of the construction project.

The administrator shall maintain a record of the contractors and subcontractors whose employees are covered under the certificate issued to the self-insured employer. A self-insuring employer immediately shall notify the administrator when any contractor or subcontractor is added or eliminated from inclusion under the certificate.

Upon approval of the application, the self-insuring employer is responsible for the administration and payment of all claims under this chapter and Chapter 4121. of the Revised Code for the employees of the contractor and subcontractors covered under the certificate who receive injuries or are killed in the course of and arising out of employment on the construction project, or who contract an occupational disease in the course of employment on the construction project. For purposes of this chapter and Chapter 4121. of the Revised Code, a claim that is administered and paid in accordance with this division is considered a claim against the

self-insuring employer listed in the certificate. A contractor or subcontractor included under the certificate shall report to the self-insuring employer listed in the certificate, all claims that arise under this chapter and Chapter 4121. of the Revised Code in connection with the construction project for which the certificate is issued.

A self-insuring employer who complies with this division is entitled to the protections provided under this chapter and Chapter 4121. of the Revised Code with respect to the employees of the contractors and subcontractors covered under a certificate issued under this division for death or injuries that arise out of, or death, injuries, or occupational diseases that arise in the course of, those employees' employment on that construction project, as if the employees were employees of the self-insuring employer, provided that the self-insuring employer also complies with this section. No employee of the contractors and subcontractors covered under a certificate issued under this division shall be considered the employee of the self-insuring employer listed in that certificate for any purposes other than this chapter and Chapter 4121. of the Revised Code. Nothing in this division gives a self-insuring employer authority to control the means, manner, or method of employment of the employees of the contractors and subcontractors covered under a certificate issued under this division.

The contractors and subcontractors included under a certificate issued under this division are entitled to the protections provided under this chapter and Chapter 4121. of the Revised Code with respect to the contractor's or subcontractor's employees who are employed on the construction project which is the subject of the certificate, for death or injuries that arise out of, or death, injuries, or occupational diseases that arise in the course of, those employees' employment on that construction

project.

The contractors and subcontractors included under a certificate issued under this division shall identify in their payroll records the employees who are considered the employees of the self-insuring employer listed in that certificate for purposes of this chapter and Chapter 4121. of the Revised Code, and the amount that those employees earned for employment on the construction project that is the subject of that certificate. Notwithstanding any provision to the contrary under this chapter and Chapter 4121. of the Revised Code, the administrator shall exclude the payroll that is reported for employees who are considered the employees of the self-insuring employer listed in that certificate, and that the employees earned for employment on the construction project that is the subject of that certificate, when determining those contractors' or subcontractors' premiums or assessments required under this chapter and Chapter 4121. of the Revised Code. A self-insuring employer issued a certificate under this division shall include in the amount of paid compensation it reports pursuant to division (L) of this section, the amount of paid compensation the self-insuring employer paid pursuant to this division for the previous calendar year.

Nothing in this division shall be construed as altering the rights of employees under this chapter and Chapter 4121. of the Revised Code as those rights existed prior to September 17, 1996. Nothing in this division shall be construed as altering the rights devolved under sections 2305.31 and 4123.82 of the Revised Code as those rights existed prior to September 17, 1996.

As used in this division, "privilege to self-insure a construction project" means privilege to pay individually compensation, and to furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees or to

reimburse a health insurer or an employee who paid a health care provider for medical benefits provided by that health care provider, pursuant to section 4123.513 of the Revised Code.

(P) A self-insuring employer whose application is granted under division (O) of this section shall designate a safety professional to be responsible for the administration and enforcement of the safety program that is specifically designed for the construction project that is the subject of the application.

A self-insuring employer whose application is granted under division (O) of this section shall employ an ombudsperson for the construction project that is the subject of the application. The ombudsperson shall have experience in workers' compensation or the construction industry, or both. The ombudsperson shall perform all of the following duties:

(1) Communicate with and provide information to employees who are injured in the course of, or whose injury arises out of employment on the construction project, or who contract an occupational disease in the course of employment on the construction project;

(2) Investigate the status of a claim upon the request of an employee to do so;

(3) Provide information to claimants, third party administrators, employers, and other persons to assist those persons in protecting their rights under this chapter and Chapter 4121. of the Revised Code.

A self-insuring employer whose application is granted under division (O) of this section shall post the name of the safety professional and the ombudsperson and instructions for contacting the safety professional and the ombudsperson in a conspicuous place at the site of the construction project.

(Q) The administrator may consider all of the following when deciding whether to grant a self-insuring employer the privilege to self-insure a construction project as provided under division (O) of this section:

(1) Whether the self-insuring employer has an organizational plan for the administration of the workers' compensation law;

(2) Whether the safety program that is specifically designed for the construction project provides for the safety of employees employed on the construction project, is applicable to all contractors and subcontractors who perform labor or work or provide materials for the construction project, and has as a component, a safety training program that complies with standards adopted pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, and provides for continuing management and employee involvement;

(3) Whether granting the privilege to self-insure the construction project will reduce the costs of the construction project;

(4) Whether the self-insuring employer has employed an ombudsperson as required under division (P) of this section;

(5) Whether the self-insuring employer has sufficient surety to secure the payment of claims for which the self-insuring employer would be responsible pursuant to the granting of the privilege to self-insure a construction project under division (O) of this section.

(R) As used in divisions (O), (P), and (Q), "self-insuring employer" includes the following employers, whether or not they have been granted the status of being a self-insuring employer under division (B) of this section:

(1) A state institution of higher education;

(2) A school district;

(3) A county school financing district;

(4) An educational service center;

(5) A community school established under Chapter 3314. of the Revised Code.

(S) As used in this section:

(1) "Unvoted debt capacity" means the amount of money that a public employer may borrow without voter approval of a tax levy;

(2) "State institution of higher education" means the state universities listed in section 3345.011 of the Revised Code, community colleges created pursuant to Chapter 3354. of the Revised Code, university branches created pursuant to Chapter 3355. of the Revised Code, technical colleges created pursuant to Chapter 3357. of the Revised Code, and state community colleges created pursuant to Chapter 3358. of the Revised Code.

Sec. 4123.511. (A) ~~Within~~ If a health care provider provides services to an employee who suffers an injury or contracts an occupational disease that may be compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code and the employee has health insurance, the health care provider shall submit a claim to the employee's health insurer and shall include a statement with the bill that the employee's injury or occupational disease may be compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code. Within three days after receiving such a claim from a health care provider, the health insurer shall file a claim with the bureau of workers' compensation regarding the alleged injury or occupational disease. If a health care provider provides services to an employee who suffers an injury or contracts an occupational disease that may be compensable under this chapter or Chapter 4121., 4127., or 4131.

of the Revised Code and the employee does not have health insurance, the health care provider, employee, or employer shall file a claim with the bureau regarding the alleged injury or occupational disease.

Within seven days after receipt of any claim under this chapter, the bureau ~~of workers' compensation~~ shall notify the claimant and the employer of the claimant of the receipt of the claim and of the facts alleged therein. If the bureau receives from a person other than the claimant written or facsimile information or information communicated verbally over the telephone indicating that an injury or occupational disease has occurred or been contracted which may be compensable under this chapter, the bureau shall notify the employee and the employer of the information. If the information is provided verbally over the telephone, the person providing the information shall provide written verification of the information to the bureau according to division (E) of section 4123.84 of the Revised Code. The receipt of the information in writing or facsimile, or if initially by telephone, the subsequent written verification, and the notice by the bureau shall be considered an application for compensation under section 4123.84 or 4123.85 of the Revised Code, provided that the conditions of division (E) of section 4123.84 of the Revised Code apply to information provided verbally over the telephone. Upon receipt of a claim, the bureau shall advise the claimant of the claim number assigned and the claimant's right to representation in the processing of a claim or to elect no representation. If the bureau determines that a claim is determined to be a compensable lost-time claim, the bureau shall notify the claimant and the employer of the availability of rehabilitation services. No bureau or industrial commission employee shall directly or indirectly convey any information in derogation of this right. This section shall in no way abrogate the bureau's responsibility to aid and assist a claimant in the

filing of a claim and to advise the claimant of the claimant's rights under the law.

The administrator of workers' compensation shall assign all claims and investigations to the bureau service office from which investigation and determination may be made most expeditiously.

The bureau shall investigate the facts concerning an injury or occupational disease and ascertain such facts in whatever manner is most appropriate and may obtain statements of the employee, employer, attending physician, and witnesses in whatever manner is most appropriate.

The administrator of workers' compensation, with the advice and consent of the workers' compensation oversight commission, may adopt rules that identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The administrator may grant immediate allowance of any medical condition identified in those rules upon the filing of a claim involving that medical condition and may make immediate payment of medical bills for any medical condition identified in those rules that is included in a claim. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, payment for the medical condition included in that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section, in claims other than those in which the employer is a self-insuring employer, if the administrator determines under division (A) of this section that a claimant is or is not entitled to an award of compensation or benefits, the administrator shall issue an order no later than twenty-eight days after the sending of the notice under division (A) of this section, granting or denying the payment of the compensation or benefits, or both as is

appropriate to the claimant. Notwithstanding the time limitation specified in this division for the issuance of an order, if a medical examination of the claimant is required by statute, the administrator promptly shall schedule the claimant for that examination and shall issue an order no later than twenty-eight days after receipt of the report of the examination. The administrator shall notify the claimant and the employer of the claimant and their respective representatives in writing of the nature of the order and the amounts of compensation and benefit payments involved. The employer or claimant may appeal the order pursuant to division (C) of this section within fourteen days after the date of the receipt of the order. The employer and claimant may waive, in writing, their rights to an appeal under this division.

(2) Notwithstanding the time limitation specified in division (B)(1) of this section for the issuance of an order, if the employer certifies a claim for payment of compensation or benefits, or both, to a claimant, and the administrator has completed the investigation of the claim, the payment of benefits or compensation, or both, as is appropriate, shall commence upon the later of the date of the certification or completion of the investigation and issuance of the order by the administrator, provided that the administrator shall issue the order no later than the time limitation specified in division (B)(1) of this section.

(3) If an appeal is made under division (B)(1) or (2) of this section, the administrator shall forward the claim file to the appropriate district hearing officer within seven days of the appeal. In contested claims other than state fund claims, the administrator shall forward the claim within seven days of the administrator's receipt of the claim to the commission, which shall refer the claim to an appropriate district hearing officer

for a hearing in accordance with division (C) of this section.

(C) If an employer or claimant timely appeals the order of the administrator issued under division (B) of this section or in the case of other contested claims other than state fund claims, the commission shall refer the claim to an appropriate district hearing officer according to rules the commission adopts under section 4121.36 of the Revised Code. The district hearing officer shall notify the parties and their respective representatives of the time and place of the hearing.

The district hearing officer shall hold a hearing on a disputed issue or claim within forty-five days after the filing of the appeal under this division and issue a decision within seven days after holding the hearing. The district hearing officer shall notify the parties and their respective representatives in writing of the order. Any party may appeal an order issued under this division pursuant to division (D) of this section within fourteen days after receipt of the order under this division.

(D) Upon the timely filing of an appeal of the order of the district hearing officer issued under division (C) of this section, the commission shall refer the claim file to an appropriate staff hearing officer according to its rules adopted under section 4121.36 of the Revised Code. The staff hearing officer shall hold a hearing within forty-five days after the filing of an appeal under this division and issue a decision within seven days after holding the hearing under this division. The staff hearing officer shall notify the parties and their respective representatives in writing of the staff hearing officer's order. Any party may appeal an order issued under this division pursuant to division (E) of this section within fourteen days after receipt of the order under this division.

(E) Upon the filing of a timely appeal of the order of the staff hearing officer issued under division (D) of this section,

the commission or a designated staff hearing officer, on behalf of the commission, shall determine whether the commission will hear the appeal. If the commission or the designated staff hearing officer decides to hear the appeal, the commission or the designated staff hearing officer shall notify the parties and their respective representatives in writing of the time and place of the hearing. The commission shall hold the hearing within forty-five days after the filing of the notice of appeal and, within seven days after the conclusion of the hearing, the commission shall issue its order affirming, modifying, or reversing the order issued under division (D) of this section. The commission shall notify the parties and their respective representatives in writing of the order. If the commission or the designated staff hearing officer determines not to hear the appeal, within fourteen days after the filing of the notice of appeal, the commission or the designated staff hearing officer shall issue an order to that effect and notify the parties and their respective representatives in writing of that order.

Except as otherwise provided in this chapter and Chapters 4121., 4127., and 4131. of the Revised Code, any party may appeal an order issued under this division to the court pursuant to section 4123.512 of the Revised Code within sixty days after receipt of the order, subject to the limitations contained in that section.

(F) Every notice of an appeal from an order issued under divisions (B), (C), (D), and (E) of this section shall state the names of the claimant and employer, the number of the claim, the date of the decision appealed from, and the fact that the appellant appeals therefrom.

(G) All of the following apply to the proceedings under divisions (C), (D), and (E) of this section:

(1) The parties shall proceed promptly and without

continuances except for good cause;

(2) The parties, in good faith, shall engage in the free exchange of information relevant to the claim prior to the conduct of a hearing according to the rules the commission adopts under section 4121.36 of the Revised Code;

(3) The administrator is a party and may appear and participate at all administrative proceedings on behalf of the state insurance fund. However, in cases in which the employer is represented, the administrator shall neither present arguments nor introduce testimony that is cumulative to that presented or introduced by the employer or the employer's representative. The administrator may file an appeal under this section on behalf of the state insurance fund; however, except in cases arising under section 4123.343 of the Revised Code, the administrator only may appeal questions of law or issues of fraud when the employer appears in person or by representative.

(H) Except as provided in section 4121.63 of the Revised Code and division (J) of this section, payments of compensation to a claimant or on behalf of a claimant as a result of any order issued under this chapter shall commence upon the earlier of the following:

(1) Fourteen days after the date the administrator issues an order under division (B) of this section, unless that order is appealed;

(2) The date when the employer has waived the right to appeal a decision issued under division (B) of this section;

(3) If no appeal of an order has been filed under this section or to a court under section 4123.512 of the Revised Code, the expiration of the time limitations for the filing of an appeal of an order;

(4) The date of receipt by the employer of an order of a

district hearing officer, a staff hearing officer, or the industrial commission issued under division (C), (D), or (E) of this section.

(I) No medical benefits payable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code are payable until the earlier of the following:

(1) The date of the issuance of the staff hearing officer's order under division (D) of this section;

(2) The date of the final administrative or judicial determination.

(J) Upon the final administrative or judicial determination under this section or section 4123.512 of the Revised Code of an appeal of an order to pay compensation, if a claimant is found to have received compensation pursuant to a prior order which is reversed upon subsequent appeal, the claimant's employer, if a self-insuring employer, or the bureau, shall withhold from any amount to which the claimant becomes entitled pursuant to any claim, past, present, or future, under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, the amount of previously paid compensation to the claimant which, due to reversal upon appeal, the claimant is not entitled, pursuant to the following criteria:

(1) No withholding for the first twelve weeks of temporary total disability compensation pursuant to section 4123.56 of the Revised Code shall be made;

(2) Forty per cent of all awards of compensation paid pursuant to sections 4123.56 and 4123.57 of the Revised Code, until the amount overpaid is refunded;

(3) Twenty-five per cent of any compensation paid pursuant to section 4123.58 of the Revised Code until the amount overpaid is refunded;

(4) If, pursuant to an appeal under section 4123.512 of the Revised Code, the court of appeals or the supreme court reverses the allowance of the claim, then no amount of any compensation will be withheld.

The administrator and self-insuring employers, as appropriate, are subject to the repayment schedule of this division only with respect to an order to pay compensation that was properly paid under a previous order, but which is subsequently reversed upon an administrative or judicial appeal. The administrator and self-insuring employers are not subject to, but may utilize, the repayment schedule of this division, or any other lawful means, to collect payment of compensation made to a person who was not entitled to the compensation due to fraud as determined by the administrator or the industrial commission.

(K) If a staff hearing officer or the commission fails to issue a decision or the commission fails to refuse to hear an appeal within the time periods required by this section, payments to a claimant shall cease until the staff hearing officer or commission issues a decision or hears the appeal, unless the failure was due to the fault or neglect of the employer or the employer agrees that the payments should continue for a longer period of time.

(L) Except as otherwise provided in this section or section 4123.522 of the Revised Code, no appeal is timely filed under this section unless the appeal is filed with the time limits set forth in this section.

(M) No person who is not an employee of the bureau or commission or who is not by law given access to the contents of a claims file shall have a file in the person's possession.

(N) Upon application of a party who resides in an area in which an emergency or disaster is declared, the industrial

commission and hearing officers of the commission may waive the time frame within which claims and appeals of claims set forth in this section must be filed upon a finding that the applicant was unable to comply with a filing deadline due to an emergency or a disaster.

As used in this division:

(1) "Emergency" means any occasion or instance for which the governor of Ohio or the president of the United States publicly declares an emergency and orders state or federal assistance to save lives and protect property, the public health and safety, or to lessen or avert the threat of a catastrophe.

(2) "Disaster" means any natural catastrophe or fire, flood, or explosion, regardless of the cause, that causes damage of sufficient magnitude that the governor of Ohio or the president of the United States, through a public declaration, orders state or federal assistance to alleviate damage, loss, hardship, or suffering that results from the occurrence.

Sec. 4123.512. (A) The claimant or the employer may appeal an order of the industrial commission made under division (E) of section 4123.511 of the Revised Code in any injury or occupational disease case, other than a decision as to the extent of disability to the court of common pleas of the county in which the injury was inflicted or in which the contract of employment was made if the injury occurred outside the state, or in which the contract of employment was made if the exposure occurred outside the state. If no common pleas court has jurisdiction for the purposes of an appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. If the claim is for an occupational disease, the appeal shall be to the court of common pleas of the county in which the exposure which

caused the disease occurred. Like appeal may be taken from an order of a staff hearing officer made under division (D) of section 4123.511 of the Revised Code from which the commission has refused to hear an appeal. The appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order appealed from or the date of receipt of the order of the commission refusing to hear an appeal of a staff hearing officer's decision under division (D) of section 4123.511 of the Revised Code. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

If an action has been commenced in a court of a county other than a court of a county having jurisdiction over the action, the court, upon notice by any party or upon its own motion, shall transfer the action to a court of a county having jurisdiction.

Notwithstanding anything to the contrary in this section, if the commission determines under section 4123.522 of the Revised Code that an employee, employer, or their respective representatives have not received written notice of an order or decision which is appealable to a court under this section and which grants relief pursuant to section 4123.522 of the Revised Code, the party granted the relief has sixty days from receipt of the order under section 4123.522 of the Revised Code to file a notice of appeal under this section.

(B) The notice of appeal shall state the names of the claimant and the employer, the number of the claim, the date of the order appealed from, and the fact that the appellant appeals therefrom.

The administrator of workers' compensation, the claimant, and the employer shall be parties to the appeal and the court, upon the application of the commission, shall make the commission a party. The party filing the appeal shall serve a copy of the

notice of appeal on the administrator at the central office of the bureau of workers' compensation in Columbus. The administrator shall notify the employer that if the employer fails to become an active party to the appeal, then the administrator may act on behalf of the employer and the results of the appeal could have an adverse effect upon the employer's premium rates.

(C) The attorney general or one or more of the attorney general's assistants or special counsel designated by the attorney general shall represent the administrator and the commission. In the event the attorney general or the attorney general's designated assistants or special counsel are absent, the administrator or the commission shall select one or more of the attorneys in the employ of the administrator or the commission as the administrator's attorney or the commission's attorney in the appeal. Any attorney so employed shall continue the representation during the entire period of the appeal and in all hearings thereof except where the continued representation becomes impractical.

(D) Upon receipt of notice of appeal, the clerk of courts shall provide notice to all parties who are appellees and to the commission.

The claimant shall, within thirty days after the filing of the notice of appeal, file a petition containing a statement of facts in ordinary and concise language showing a cause of action to participate or to continue to participate in the fund and setting forth the basis for the jurisdiction of the court over the action. Further pleadings shall be had in accordance with the Rules of Civil Procedure, provided that service of summons on such petition shall not be required and provided that the claimant may not dismiss the complaint without the employer's consent if the employer is the party that filed the notice of appeal to court pursuant to this section. The clerk of the court shall, upon receipt thereof, transmit by certified mail a copy thereof to each

party named in the notice of appeal other than the claimant. Any party may file with the clerk prior to the trial of the action a deposition of any physician taken in accordance with the provisions of the Revised Code, which deposition may be read in the trial of the action even though the physician is a resident of or subject to service in the county in which the trial is had. The bureau of workers' compensation shall pay the cost of the stenographic deposition filed in court and of copies of the stenographic deposition for each party from the surplus fund and charge the costs thereof against the unsuccessful party if the claimant's right to participate or continue to participate is finally sustained or established in the appeal. In the event the deposition is taken and filed, the physician whose deposition is taken is not required to respond to any subpoena issued in the trial of the action. The court, or the jury under the instructions of the court, if a jury is demanded, shall determine the right of the claimant to participate or to continue to participate in the fund upon the evidence adduced at the hearing of the action.

(E) The court shall certify its decision to the commission and the certificate shall be entered in the records of the court. Appeals from the judgment are governed by the law applicable to the appeal of civil actions.

(F) The cost of any legal proceedings authorized by this section, including an attorney's fee to the claimant's attorney to be fixed by the trial judge, based upon the effort expended, in the event the claimant's right to participate or to continue to participate in the fund is established upon the final determination of an appeal, shall be taxed against the employer or the commission if the commission or the administrator rather than the employer contested the right of the claimant to participate in the fund. The attorney's fee shall not exceed forty-two hundred dollars.

(G) If the finding of the court or the verdict of the jury is in favor of the claimant's right to participate in the fund, the commission and the administrator shall thereafter proceed in the matter of the claim as if the judgment were the decision of the commission, subject to the power of modification provided by section 4123.52 of the Revised Code.

(H) An appeal from an order issued under division (E) of section 4123.511 of the Revised Code or any action filed in court in a case in which an award of compensation has been made shall not stay the payment of compensation under the award or payment of compensation for subsequent periods of total disability during the pendency of the appeal. If, in a final administrative or judicial action, it is determined that payments of compensation or benefits, or both, made to or on behalf of a claimant should not have been made, the amount thereof shall be charged to the surplus fund under division (B) of section 4123.34 of the Revised Code. In the event the employer is a state risk, the amount shall not be charged to the employer's experience. In the event the employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code.

A self-insuring employer may elect to pay compensation and benefits under this section directly to <u>or on behalf of</u> an employee or an employee's dependents by filing an application with the bureau of workers' compensation not more than one hundred eighty days and not less than ninety days before the first day of the employer's next six-month coverage period. If the self-insuring employer timely files the application, the application is effective on the first day of the employer's next six-month coverage period, provided that the administrator shall compute the employer's assessment for the surplus fund due with

respect to the period during which that application was filed without regard to the filing of the application. On and after the effective date of the employer's election, the self-insuring employer shall pay directly to or on behalf of an employee or to an employee's dependents compensation and benefits under this section regardless of the date of the injury or occupational disease, and the employer shall receive no money or credits from the surplus fund on account of those payments and shall not be required to pay any amounts into the surplus fund on account of this section. The election made under this division is irrevocable.

All actions and proceedings under this section which are the subject of an appeal to the court of common pleas or the court of appeals shall be preferred over all other civil actions except election causes, irrespective of position on the calendar.

This section applies to all decisions of the commission or the administrator on November 2, 1959, and all claims filed thereafter are governed by sections 4123.511 and 4123.512 of the Revised Code.

Any action pending in common pleas court or any other court on January 1, 1986, under this section is governed by former sections 4123.514, 4123.515, 4123.516, and 4123.519 and section 4123.522 of the Revised Code.

Sec. 4123.513. (A) During the time period in which an employee's workers' compensation claim is pending under section 4123.511 or 4123.512 of the Revised Code, an employee who suffers an injury or who contracts an occupational disease shall use the employee's health insurance to pay the medical bills for the services provided to care for the injury or occupational disease. If the employee does not have health insurance, the employee may pay those medical bills directly. An employee may use the

employee's health savings account or medical savings account to pay any medical bills accrued in the claim.

(1) If a health care provider provides services to an employee for an injury or occupational disease and that employee has health insurance, the health care provider shall submit all medical bills that accrue as a result of that injury or occupational disease to the employee's health insurer for reimbursement until the health care provider receives the notice described in division (B)(2) of this section. Notwithstanding section 3901.71 of the Revised Code, the employee's health insurer shall pay all medical bills that the health insurer receives for that injury or occupational disease in accordance with the employee's health insurance policy, contract, or agreement unless the health insurer receives the notice described in division (B)(2) of this section. The health insurer shall maintain copies of all medical bills the health insurer pays for treatment of that injury or occupational disease.

A health care provider may bill an employee directly for any services rendered for that employee's injury or occupational disease that are not covered by the employee's health insurance policy, contract, or agreement. A health care provider may charge or assess the employee a copayment in accordance with the provisions of the employee's health insurance policy, contract, or agreement. If the employee pays any medical bill, copayments, or any part of a deductible, the employee shall maintain copies of all those medical bills, copayments, or parts of a deductible the employee paid.

(2) If a health care provider provides services to an employee for an injury or occupational disease and that employee does not have health insurance, the health care provider may bill the employee directly for all services rendered for that employee's injury or occupational disease. The employee shall

maintain copies of all medical bills the employee paid for that injury or occupational disease.

(3) If an employee uses funds from a health savings account or a medical savings account to pay for any medical bills for services rendered for the employee's injury or occupational disease, the employee shall maintain copies of those bills and indicate on those copies that the employee used funds from a health savings account or medical savings account to pay for those bills.

(B) Within five days after a final determination is made concerning an employee's eligibility to receive compensation and benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for the employee's injury or occupational disease pursuant to section 4123.511 or 4123.512 of the Revised Code, the administrator of workers' compensation shall send to the employer, the employee, the employee's health insurer, if applicable, and the employee's health care provider the appropriate written notice described in division (B)(1) or (2) of this section.

(1) If a final determination is made that an employee is not eligible to receive compensation and benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for that injury or occupational disease, the administrator shall include all of the following statements in a written notice:

(a) The employee is ineligible to receive workers' compensation and benefits for the employee's injury or occupational disease.

(b) The health care provider shall continue billing the health insurer or employee, as applicable, for services rendered by that health care provider to treat the employee's injury or occupational disease.

(c) If a health insurer is covering the service rendered by a

health care provider for the employee's injury or occupational disease, the health insurer shall continue providing coverage in accordance with the provisions of the employee's health insurance policy, contract, or agreement.

(2) If a final determination is made that the employee is eligible to receive compensation and benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for the employee's injury or occupational disease, the administrator shall include all of the following statements in a written notice:

(a) The employee is eligible to receive workers' compensation and benefits for the employee's injury or occupational disease.

(b) The health care provider shall cease billing the employee's health insurer or employee and shall submit all bills for that employee's injury or occupational disease with a date of service on or after the date that the final determination is made, to the administrator, or if the employee's employer is a self-insuring employer, to the employer, for payment.

(c) If a health insurer paid a health care provider for services rendered for that claim prior to the date that the final determination is made, the health insurer shall submit copies of all invoices paid by the health insurer for that claim to the administrator, or if the employee's employer is a self-insuring employer, to the employer, and include the employee's claim number on each copy of an invoice that the health insurer submits.

(d) If an employee paid any medical bills, copayments, or part of a deductible, or used a health savings account or medical savings account to pay a bill, the employee shall submit copies of all bills paid to the administrator or, if the employee's employer is a self-insuring employer, to the employer, and shall include the employee's claim number on each copy of a bill that the employee submits.

(C) Except as provided in division (D) of this section, upon receipt of the copies of medical bills paid by a health insurer or employee, the administrator, or the employee's employer, if the employee's employer is a self-insuring employer, shall reimburse the health insurer or the employee for any medical bill the health insurer or employee paid for that claim on the condition that the services rendered for that medical bill are compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code. The administrator or self-insuring employer, as appropriate, also shall reimburse an employee for any copayments and any part of a deductible that the employee paid for that compensable claim.

(D) Upon receipt of a copy of a medical bill from an employee that indicates that the employee used funds from a health savings account or medical savings account to pay that bill, the administrator or self-insuring employer, as appropriate, shall send the reimbursement for that bill to the trustee or custodian of the health savings account or medical savings account, who shall deposit the reimbursement in the employee's health savings account or medical savings account, as applicable, on behalf of the employee. The administrator or self-insuring employer shall reimburse only those bills that are compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(E) Beginning on the date that a final determination is made that an employee is eligible to receive compensation or benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code, the administrator or self-insuring employer, as appropriate, shall commence payment of the medical bills for that employee's claim.

(F) As used in this section:

(1) "Final determination" means the later of the date that any of the following occur:

(a) The decision by the administrator, the industrial commission, or a court allowing compensation or benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code to an employee or an employee's dependents from which there is no further right to reconsideration or appeal that would require the bureau of workers' compensation or a self-insuring employer to withhold the payment of medical benefits;

(b) The rights to reconsideration or appeal have expired without the employee or employer applying for reconsideration or appeal;

(c) The application for reconsideration or appeal is withdrawn.

(2) "Health savings account" means a health insurance plan that complies with the provisions of section 223 of the "Internal Revenue Code of 1986," 26 U.S.C. 223, as amended.

(3) "Medical savings account" means a health insurance plan that complies with the provisions of section 220 of the "Internal Revenue Code of 1986," 26 U.S.C. 220, as amended.

Sec. 4123.82. (A) All contracts and agreements are void which undertake to indemnify or insure an employer against loss or liability for the payment of compensation to workers or their dependents for death, injury, or occupational disease occasioned in the course of the workers' employment, or which provide that the insurer shall pay the compensation, or which indemnify the employer against damages when the injury, disease, or death arises from the failure to comply with any lawful requirement for the protection of the lives, health, and safety of employees, or when the same is occasioned by the willful act of the employer or any of ~~his~~ the employer's officers or agents, or by which it is agreed that the insurer shall pay any such damages. No license or authority to enter into any such agreements or issue any such

policies of insurance shall be granted or issued by any public authority in this state. Any corporation organized or admitted under the laws of this state to transact liability insurance as defined in section 3929.01 of the Revised Code may by amendment of its articles of incorporation or by original articles of incorporation, provide therein for the authority and purpose to make insurance in states, territories, districts, and counties, other than the state of Ohio, and in the state of Ohio in respect of contracts permitted by division (B) of this section, indemnifying employers against loss or liability for payment of compensation to workers and employees and their dependents for death, injury, or occupational disease occasioned in the course of the employment and to insure and indemnify employers against loss, expense, and liability by risk of bodily injury or death by accident, disability, sickness, or disease suffered by workers and employees for which the employer may be liable or has assumed liability.

(B) Notwithstanding division (A) of this section:

(1) No contract because of that division is void which undertakes to indemnify a self-insuring employer against all or part of such employer's loss in excess of at least fifty thousand dollars from any one disaster or event arising out of the employer's liability under this chapter, but no insurance corporation shall, directly or indirectly, represent an employer in the settlement, adjudication, determination, allowance, or payment of claims. The superintendent of insurance shall enforce this prohibition by such disciplinary orders directed against the offending insurance corporation as the superintendent of insurance deems appropriate in the circumstances and the administrator of workers' compensation shall enforce this prohibition by such disciplinary orders directed against the offending employer as the administrator deems appropriate in the circumstances, which orders

may include revocation of the insurance corporation's right to enter into indemnity contracts and revocation of the employer's status as a self-insuring employer.

(2) The administrator may enter into a contract of indemnity with any such employer upon such terms, payment of such premium, and for such amount and form of indemnity as the administrator determines and the administrator may procure reinsurance of the liability of the public and private funds under this chapter, or any part of the liability in respect of either or both of the funds, upon such terms and premiums or other payments from the fund or funds as the administrator deems prudent in the maintenance of a solvent fund or funds from year to year. When making the finding of fact which the administrator is required by section 4123.35 of the Revised Code to make with respect to the financial ability of an employer, no contract of indemnity, or the ability of the employer to procure such a contract, shall be considered as increasing the financial ability of the employer.

(3) A health insurance contract, policy, or agreement that undertakes to provide coverage of medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, or other similar benefits for an injury or occupational disease that may be covered under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code is not void provided that the contract, policy, or agreement includes a provision stating that coverage for that injury or occupational disease ceases once a final determination is made under section 4123.511 or 4123.512 of the Revised Code stating that the claim is compensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(C) Nothing in this section shall prohibit an employee from using the employee's health insurance or directly paying for medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, or other

similar benefits for an injury the employee suffered or occupational disease the employee contracted.

Sec. 4123.93. As used in sections 4123.93 and 4123.931 of the Revised Code:

(A) "Claimant" means a person who is eligible to receive compensation, medical benefits, or death benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(B) "Statutory subrogee" means the administrator of workers' compensation, a self-insuring employer, or an employer that contracts for the direct payment of medical services pursuant to division ~~(L)~~(J) of section 4121.44 of the Revised Code.

(C) "Third party" means an individual, private insurer, public or private entity, or public or private program that is or may be liable to make payments to a person without regard to any statutory duty contained in this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(D) "Subrogation interest" includes past, present, and estimated future payments of compensation, medical benefits, rehabilitation costs, or death benefits, and any other costs or expenses paid to or on behalf of the claimant by the statutory subrogee pursuant to this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(E) "Net amount recovered" means the amount of any award, settlement, compromise, or recovery by a claimant against a third party, minus the attorney's fees, costs, or other expenses incurred by the claimant in securing the award, settlement, compromise, or recovery. "Net amount recovered" does not include any punitive damages that may be awarded by a judge or jury.

(F) "Uncompensated damages" means the claimant's demonstrated or proven damages minus the statutory subrogee's subrogation

interest.

Section 2. That existing sections 126.30, 1751.55, 1751.60, 3923.05, 3923.36, 3923.65, 3923.66, 3923.75, 3924.61, 4121.01, 4121.44, 4121.441, 4121.442, 4123.01, 4123.30, 4123.343, 4123.35, 4123.511, 4123.512, 4123.82, and 4123.93 of the Revised Code are hereby repealed.

Section 3. This act applies to all claims pursuant to Chapters 4121., 4123., 4127., and 4131. of the Revised Code arising on and after the effective date of this act.

Section 4. This act applies to all individual or group policies for sickness and accident insurance entered into on or after the effective date of this act and all policies, contracts, or agreements entered into between a subscriber and a health insuring corporation on or after the effective date of this act.